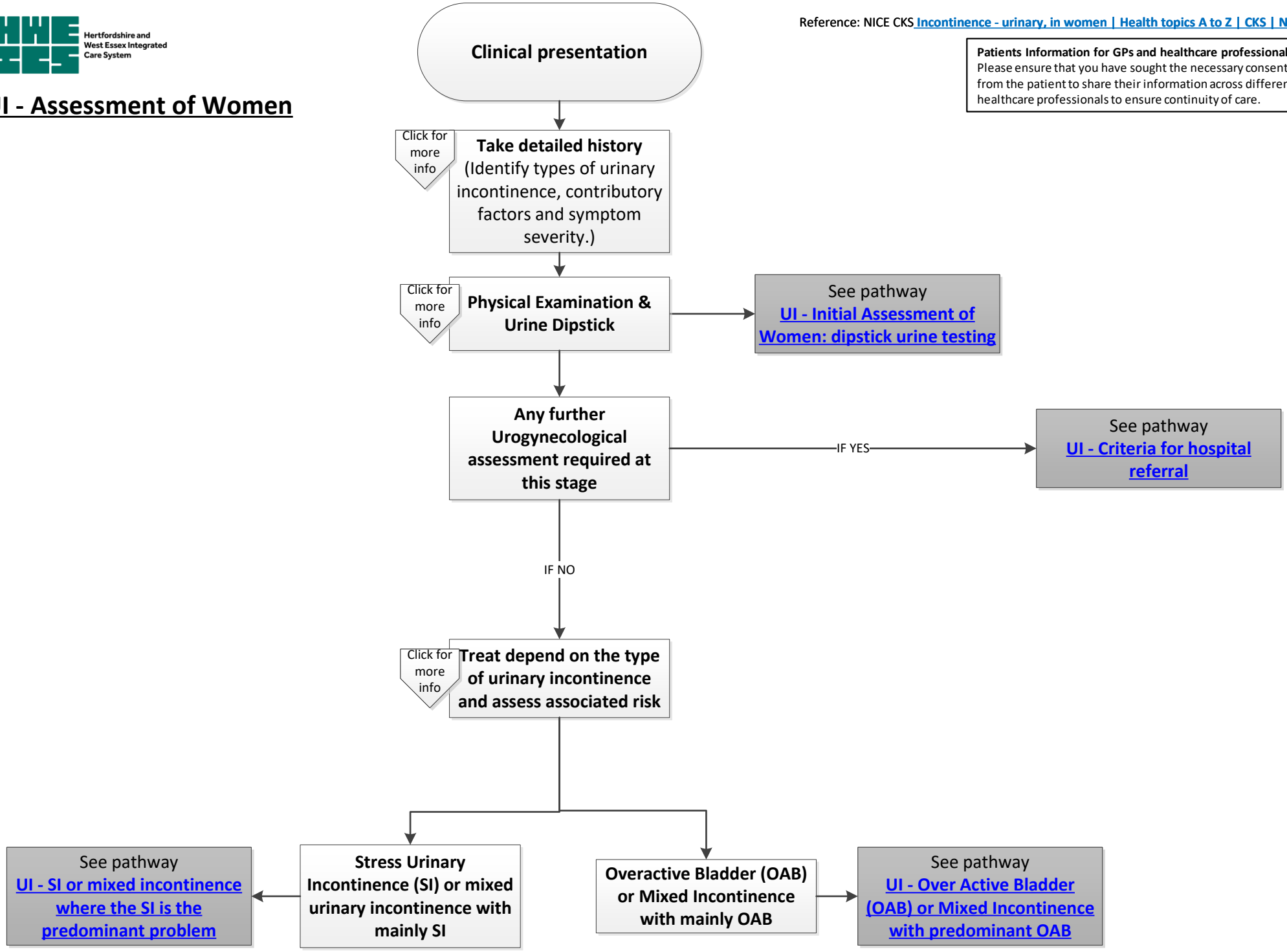
Hertfordshire and West Essex Integrated Care System

UI - Assessment of Women

Reference: NICE CKS Incontinence - urinary, in women | Health topics A to Z | CKS | NICE

Patients Information for GPs and healthcare professionals
Please ensure that you have sought the necessary consent from the patient to share their information across different healthcare professionals to ensure continuity of care.



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Types of Incontinence

Take a detailed history and categorize the symptoms as:

- Stress urinary incontinence.
- Urgency urinary incontinence with or without overactive bladder syndrome.
- Mixed urinary incontinence.
- Incontinence due to another cause, such as overflow incontinence (caused by chronic urinary retention), a urogenital fistula, or urethral diverticulum.

When taking the woman's history:

Ask:

- If incontinence occurs when coughing, sneezing, or on effort or exertion (likely to be stress urinary incontinence), or
- If there is sudden urgency, and if they have frequency and nocturia (likely to be urgency incontinence associated with overactive bladder syndrome).
- If incontinence occurs about equally with physical activity and urgency (suggests mixed incontinence).
- If incontinence occurs without physical activity or a sense of urgency (suggests a cause other than stress or urgency incontinence).
- If the incontinence is not characterized by stress or urgency incontinence, ask about:
- Voiding difficulty (for example straining to void, sensation of incomplete emptying) — may suggest chronic urinary retention (overflow incontinence).
- Constant leakage of urine (may be intermittent if position dependent) — suggestive of a fistula (for example vesicovaginal).
- Post-void dribbling, pain, urgency, frequency, recurrent urinary tract infection, vaginal discharge, and dyspareunia — consider a urethral diverticulum.

Use:

- Validated symptom and quality of life questionnaire e.g. ICIQ-UI Short Form ICIQ-UI SF | ICIQ

Consider and look for the presence of any causes or conditions that may exacerbate urinary incontinence or overactive bladder:

- Ask about fluid intake and the amount and type of fluids, for example, caffeine and alcohol.
- Identify symptoms indicating an increased likelihood of a more serious diagnosis, for example, haematuria, persisting bladder or urethral pain, recurrent urinary tract infection, constant leakage (suggests a fistula).
- Ask about any drugs the woman is taking that could be causing or exacerbating the incontinence.
- Drugs that may be associated with urinary incontinence include alpha-1 adrenoceptor antagonists, antipsychotics, anticholinergics, anti-parkinsonism drugs, antidepressants, benzodiazepines, beta-adrenoceptor antagonists, diuretics, and hormone replacement therapy.
- Ask about previous history of investigations and treatment, urinary tract disorders, low spinal surgery, prolapse or hysterectomy, and obstetric and gynaecological history.
- Consider and look for neurological conditions, for example, multiple sclerosis, spinal cord injury, Parkinson's disease.
- Consider and look for systemic disease, such as heart failure and diabetes mellitus.
- Consider and look for cognitive impairment.

To determine how severe the urinary incontinence is:

- Ask how often the woman is incontinent, at what times, and during which activities.
- Ask about the use of pads (including pad size) or changing of clothing.
- Ask the woman how often she passes urine, including at night.
- Ask the woman to keep a bladder diary for a minimum of 3 days, making sure that variations in her usual activities (for example working and leisure days) are covered.
- The diary should document the amount, type, and timing of fluids she drinks, voided volume, frequency of micturition, episodes of urgency, episodes of incontinence, activities causing leakage, and pad and clothing changes.

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On Examination:

- **Perform a general examination**, looking for features such as weight, abnormalities of gait, and indicators of neurological disease.
- **Examine the abdomen for a palpable bladder or a mass.**
- **Perform a pelvic examination**
    - **During the pelvic examination:**
        - Ask the woman to cough with a comfortably full bladder and observe the external urethral meatus for leakage (suggests that stress urinary incontinence is likely).
        - Look for potential causes of urinary incontinence:

        Evidence of pelvic organ prolapse.
        Urethral diverticulum — a sac-like protrusion between the periurethral tissues and the anterior vaginal wall.
        Atrophic vaginitis.
        Pelvic mass:
        - If it is not bladder or fibroid, see Gynaecological cancer suspected pathway.
        - If suspect bladder and has of urinary retention with overflow consider referral to acute medicine.
        - If suspect it is fibroid, consider USS and CA125 and manage accordingly.
        - **Consider assessing pelvic floor muscle contractions digitally, if there is no mass or significant prolapse:**

The strength of pelvic floor muscle contractions may be assessed digitally. A modified Oxford grading system may be used to quantify the strength of the contraction [Laycock, 2001]:
0 = no contraction. No discernible muscle contraction.
1 = flicker. A flicker or pulsation is felt under the examiner's finger.
2 = weak. An increase in tension is detected, without any discernible lift.
3 = moderate. There is lifting of the muscle belly and also elevation of the posterior vaginal wall.
4 = good. Increased tension and a good contraction elevate the posterior vaginal wall against resistance (pressure by the examining finger applied to the posterior vaginal wall).
5 = strong. Strong resistance is applied to the elevation of the posterior vaginal wall. The examiner's finger is squeezed and drawn into the vagina.

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Review women with urinary incontinence for associated risk:

- **Assess the woman's renal function —** acute kidney injury (AKI) may be present if there is urinary obstruction and will require urgent management.
  - For more information, see the CKS topic on Acute kidney injury.

- **Assess for the presence of depression.**
  - For more information on how to assess for and manage depression, see the CKS topic on Depression.

- **Assess the woman for risk of falls and fractures.**
  - For more information, see the CKS topics on Falls - risk assessment and Osteoporosis - prevention of fragility fractures.

- **Assess the woman for insomnia.**
  - For more information, see the CKS topic on Insomnia.
- **Assess for the effect on the woman's quality of life:**
  - Ask about the effect on her social life and sexual functioning.
- **Assess the impact of urinary incontinence on the person's family and/or carers.**